6. PAST HEALTH HISTORY

PATIENT NAME:

Do you have any of the following? **Please check YES or NO for each condition.**

Relative Contraindications:			Absolute Contraindications:		
Articular Hypermobility Disease	☐Yes	☐No	Rheumatoid Arthritis	☐Yes	☐No
Severe Demineralization of Bone	☐Yes	☐No	Ankylosing Spondylitis	☐Yes	☐No
Benign Bone Tumor (Spine)	☐Yes	☐No	Fracture(s)_____	☐Yes	☐No
Bleeding Disorder	☐Yes	☐No	Dislocation(s)_____	☐Yes	☐No
Are you taking Anticoagulants Therapy	☐Yes	☐No	Unstable OS Odontoedum	☐Yes	☐No
Radiculopathy with Progressive Neurological Signs,			Malignancies	☐Yes	☐No
Radiating Pain, Numbness or Weakness into:			Infection of bones or joints of the vertebral column	☐Yes	☐No
Upper Extremities	☐Yes	☐No	Myelopathy	☐Yes	☐No
Lower Extremities	☐Yes	☐No	Cauda Equina Syndrome	☐Yes	☐No
Do you have a Pacemaker or any other Electrical Implant	☐Yes	☐No	Major Artery Aneurysm	☐Yes	☐No

Previous Major Illnesses and Injuries_____

Operations, Hospitalizations, Surgeries_____

Check off Conditions that You are Currently Taking Medications for: ☐None

High Blood Pressure_____ **Cholesterol**_____ **Pain**_____ **Arthritis**_____

Depression_____ **Anxiety**_____ **ADD/ADHD**_____ **Insulin**_____

Other_____

Allergies

FAMILY HISTORY -**Immediate Family Members (Father, Mother, Brother, Sister)**

Health Status of family Members:_____

Are there any family members that suffer from:

☐Stroke ☐ Heart Disease ☐Cancer ☐Tumor ☐Degenerative Disc Disease ☐Arthritis ☐Osteoporosis

☐Other_____

If any of the above items are checked, then whom in your family suffers?_____

_____

Are there any diseases that are "hereditary" or seem to run in your family?

SOCIAL HISTORY - **Please answer the following:**

Please tell the Doctor about your activities:

Exercise:	Work/School:	Habits: ☐None			Education:
☐None	☐Sitting	☐Smoking – Packs Per Day____	☐None Drugs _____	☐None	☐High School
☐Occasional	☐Standing	☐Alcohol –Times Per Week_____	☐None		☐Some College
☐Daily	☐Light Labor	☐Caffeine: Coffee, Tea, Sodas…Cups Per Day_____		☐None	☐College Grad
☐Weekly	☐Heavy Labor	Hobbies_____		☐None	☐Post Grad
☐Other	☐Computer				

I certify the information on these forms are true to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic and therapeutic care for my condition if I am accepted as a patient

Patient Signature_____ **Date** ___/___/___

Doctors Signature_____ **Date** ___/___/___